

Glenlaurel Care Limited - Lexham Gardens Rest Home

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by The DAA Group Limited, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity:	Glenlaurel Care Limited
Premises audited:	Lexham Gardens Rest Home
Services audited:	Hospital services - Geriatric services (excl. psychogeriatric); Rest home care (excluding dementia care)
Dates of audit:	Start date: 30 July 2019 End date: 31 July 2019
Proposed changes to current services (if any):	This audit includes review of a reconfiguration related to changing eight rest home level beds to dual purpose beds with no change to overall capacity. This occurred in April 2019.
Total beds occupied across all premises included in the audit on the first day of the audit:	49

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

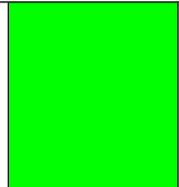
General overview of the audit

Lexham Gardens Rest Home (Lexham Gardens) provides rest home and geriatric hospital care for up to 50 residents. The service is operated by Glenlaurel Care Limited and managed by the facility manager and a clinical manager. Residents and family spoke positively about the care provided.

This certification audit was conducted against the Health and Disability Services Standards and the service's contract with the district health board. In April 2019 approval from the Ministry of Health (MoH) was granted to change eight rest home level beds to dual purpose with no increase in capacity. These changes were also reviewed as part of this audit. The audit process included review of policies and procedures, review of residents' and staff records, observations and interviews with residents, family members, managers, staff and a general practitioner.

The audit has resulted in three continuous improvement ratings in relation to adverse events management, education and medication management. No areas requiring improvement were identified in relation to the certification audit and/or the change approved for additional dual purpose beds.

Consumer rights

<p>Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.</p>		<p>Standards applicable to this service fully attained.</p>
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Residents and their families are provided with information about the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights (the Code) and these are respected. Services are provided that support personal privacy, independence, individuality and dignity. Staff interact with residents in a respectful manner. Resident's choices are respected including via the development of end of life care plans.

Open communication between staff, residents and families is promoted, and confirmed to be effective. There is access to interpreting services if required. Staff provide residents and families with the information they need to make informed choices and give consent.

There are processes in place to facilitate meeting the needs of residents who identify as Māori. Services are provided in a manner that respects residents' individual cultural values and beliefs. There was no evidence of abuse, neglect or discrimination.

The service has linkages with a range of specialist health care providers to support best practice and meet resident's needs.

A complaints register is maintained with complaints resolved promptly and effectively.

Organisational management

<p>Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.</p>		<p>Standards applicable to this service fully attained.</p>
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Business, quality and risk management plans reviewed included the scope, direction, objectives and values of the organisation. Monitoring of the services is provided to the governing body regularly and effectively. An experienced and suitably qualified person manages the facility.

The quality and risk management system includes collection of data and analysis. Any trends are identified which leads to quality improvement. Staff are involved and feedback mechanisms are in place. Adverse events are well documented with corrective action plans implemented. Risks, including health and safety risks, are identified and mitigated. Policies and procedures support service delivery and were current.

The appointment of staff is based on current good practice. Full orientation is provided to new staff and ongoing training supports safe service provision and includes the completion of staff annual appraisals. Staffing levels and skill mix meet the changing needs of the residents.

Residents' records are documented in a timely manner, in accordance with current accepted standards and are stored securely.

Continuum of service delivery

Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.		Standards applicable to this service fully attained.
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Access to the facility is appropriate and efficiently managed with relevant information provided to the potential resident/family.

The multidisciplinary team, including the registered nurses and a general practitioner, assess residents' needs on admission. Care plans are individualised, based on a comprehensive range of information and assessments and accommodate any new problems that might arise. Files reviewed demonstrated that the care provided and needs of residents were reviewed and evaluated on a regular and timely basis. Residents are referred or transferred to other health services as required.

The planned activity programme provides residents with a variety of individual and group activities and maintains their links with the community.

Medicines are stored securely and administered by staff who are competent to do so.

The food service meets the nutritional needs of the residents with special needs catered for. Food is safely managed. The rest home has a registered food safety plan and food services are provided in accordance with the plan. Residents and family members verified satisfaction with meals.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.		Standards applicable to this service fully attained.
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Lexham Gardens' facilities meets the needs of residents and was well maintained, clean and tidy. There was a current building warrant of fitness and electric equipment is tested as required. Communal and individual spaces are maintained with appropriate heating at an even comfortable temperature. External areas are level and well maintained, with seating available. Shade is available in the summer months.

Waste and hazardous substances are well managed. Staff are well protected with adequate supplies of personal protective equipment being available. Chemicals are stored safely. Laundry is contracted offsite and evaluated for effectiveness.

Staff are trained in emergency procedures and emergency resources are readily available. Supplies are checked regularly. Fire evacuation procedures are held six monthly. Residents reported a timely staff response to call bells. Security is well maintained.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

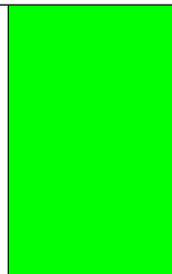


Standards applicable to this service fully attained.

The organisation has implemented policies and procedures that support the minimisation of restraint. No enablers were in use at the time of audit. Use of enablers is voluntary for the safety of residents in response to individual requests. Eleven restraints were in use. Comprehensive documentation is maintained which includes assessment, approval, monitoring and review processes. Staff interviewed demonstrated a sound knowledge and understanding of restraint minimisation and safe practice.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.



Standards applicable to this service fully attained.

The infection prevention and control programme led by the clinical manager aims to prevent and manage infections. The programme is reviewed annually. Specialist infection prevention and control advice is available when needed.

Staff demonstrated good principles and practice around infection control, which is guided by policies and supported with regular education.

The infection surveillance programme is relevant to the service setting and results are communicated appropriately.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	50	0	0	0	0	0
Criteria	3	98	0	0	0	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
Standard 1.1.1: Consumer Rights During Service Delivery Consumers receive services in accordance with consumer rights legislation.	FA	Lexham Gardens has developed policies, procedures and processes to meet its obligations in relation to the Code of Health and Disability Services Consumers' Rights (the Code). Staff interviewed understood the requirements of the Code and were observed demonstrating respectful communication, encouraging independence, providing options, and maintaining dignity and privacy. Training on the Code is included as part of the orientation process for all staff employed and in ongoing training, as was verified in training records and human resource records sighted.
Standard 1.1.10: Informed Consent Consumers and where appropriate their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.	FA	The clinical manager, general practitioner and care staff interviewed understood the principles and practice of informed consent. Informed consent policies provide relevant guidance to staff. Clinical files reviewed showed that informed consent has been gained appropriately using the organisation's standard consent form. This includes for outings / transport, release of health information, photographs, and medical treatment. Establishing and documenting enduring power of attorney requirements and processes for residents unable to consent is defined and documented, as relevant, in the resident's record. Copies of enduring power of attorney (EPOA) and welfare guardian documents are sought and copies kept on file, along with documentation (where applicable) verifying that the EPOA document has been activated. Residents were also encouraged to detail their wishes in regard to escalation of clinical care

		<p>(cardiopulmonary resuscitation, use of antibiotics, and transfer to the district health board hospital) where applicable. Residents' choices and associated documentation have been reviewed at least annually for competent residents or following a significant change in health status. The resident's wishes are communicated to staff.</p> <p>Staff were observed to gain consent for day to day care activities. Participation in activities is voluntary.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	FA	<p>During the admission process, a discussion occurs with the resident and family about the Code and Advocacy Service. Posters and brochures related to the Code and Advocacy Service were also displayed in the facility. Family members and residents spoken with on this topic were aware of the Advocacy Service, how to access this and their right to have support persons. Family are welcome at any time to visit with residents. Staff verified that family members are welcome to visit and are encouraged to support the resident in making choices and communicating their needs.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	FA	<p>Residents are assisted to maximise their potential for self-help and to maintain links with their family and the community by attending a variety of organised outings, visits, activities, and entertainment. Staff ensure residents are ready in time for any planned outings or visits.</p> <p>The facility has unrestricted visiting hours and encourages visits from residents' family and friends. Family members interviewed stated they felt welcome when they visited and can come at any time. Family members are encouraged to accompany the resident to external health appointments. If unable to do so, the resident is accompanied by a staff member.</p> <p>Family members confirmed they were comfortable in their dealings with staff.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	FA	<p>The complaints and compliments forms and associated documents meet the requirements of Right 10 of the Code of Health and Disability Services Consumers' Rights (the Code). Information on the complaint process is provided to residents and families on admission and is placed around the facility. Those interviewed residents and family knew how to make a complaint and to give compliments.</p> <p>The complaints register reviewed showed that eight verbal complaints have been received this year and that actions taken through to an agreed resolution are documented and processes completed within the timeframes required. Action plans showed any required actions or improvements that have been made where possible. The facility manager is responsible for complaints management and any follow-up. A monthly quality initiative is to display a graph of the number of complaints and compliments in the staff room for staff to view. All staff interviewed confirmed a sound understanding of the complaint process and what</p>

		<p>actions are required.</p> <p>There have been no complaints received from external sources since the previous audit.</p>
<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	FA	<p>Residents and family members interviewed reported being made aware of the Code and the Nationwide Health and Disability Advocacy Service (Advocacy Service) through discussions on admission and via posters displayed in the rest home. Communications on the Code at admission are documented in residents' records. The Code is displayed in English, Maori and sign language. Information on advocacy services and complaint / feedback forms are readily available to residents and family members. The Care Association Code of Ethics is also displayed.</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	FA	<p>Residents and families confirmed that they receive services in a manner that has regard for their dignity, privacy, sexuality, spirituality and choices.</p> <p>Staff were observed to maintain privacy throughout the audit.</p> <p>Residents are encouraged to maintain their independence by attending community activities and participating in activities. Visitors are welcomed. Care plans included documentation related to the resident's individual abilities, and strategies to maximise independence.</p> <p>Records reviewed confirmed that each resident's individual cultural, religious and social needs, values and beliefs had been identified, documented and incorporated into their care plan. Residents and family members interviewed verified the resident's individualised needs are comprehensively met.</p> <p>Staff understood the service's policy on abuse and neglect, including what to do should there be any signs. Education on abuse and neglect was confirmed to occur during orientation and as part of the ongoing education programme. Residents and family members interviewed were very complimentary about staff and had no concerns about how staff treated, interacted or communicated with the residents, other staff, and family members</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and</p>	FA	<p>No current residents identify as Maori. There is a specific care plan that the clinical manager advised would be used to ensure the needs of Maori residents are identified and met. The template form was sighted. Policy details the principles of the Treaty of Waitangi are incorporated into day to day practice, as is the importance of whānau. Support and specific guidance on culturally appropriate care is available.</p>

acknowledges their individual and cultural, values and beliefs.		
<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	FA	<p>Residents and family members verified that they were consulted on their individual culture, values and beliefs and that staff respected these. Resident's personal preferences required interventions and special needs were included in care plans reviewed and the care plans are signed by the resident and or designated next of kin. In the sample of care plans sighted there was information about residents' individual needs including (but not limited to), culture, clothing / appearance, dietary needs, and religious beliefs / faith.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	FA	<p>Residents and family members interviewed stated that residents were free from any type of discrimination, harassment or exploitation and felt safe. Staff were commended by residents and family members interviewed for creating a safe and homely environment.</p> <p>The induction process for staff includes education related to professional boundaries, and expected staff conduct / behaviours. The organisation's expectations related to staff conduct are also clearly detailed in staff employment contracts present in all staff files sampled and 'house rules'.</p> <p>Staff are guided by policies and procedures and demonstrated a clear understanding of the process they would follow, should they suspect any form of exploitation. There have been no concerns raised by staff, residents or family since the last audit.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	FA	<p>The service encourages and promotes good practice through input from external specialist services and allied health professionals, for example, gerontology nurse specialist, wound care specialist, mental health services for older persons, and medical specialists including via the DHB when clinically appropriate and consented. The general practitioner (GP) confirmed the service sought prompt and appropriate medical intervention when required and were responsive to specialist feedback received.</p> <p>Staff reported they receive good support for internal and external education.</p> <p>Other examples of good practice observed during the audit included the use of a comprehensive range of assessments to monitor residents' progress, the move to an electronic medicines management system (refer to 1.3.12), and the frequent use of pressure relieving mattresses and cushions and sensor mats for residents at risk of developing pressure injuries or falling (refer to 1.3.6).</p>

<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Residents and family members stated they were kept well informed about any changes to their/their relative's status, were advised in a timely manner about any incidents or accidents and outcomes of regular and any urgent medical reviews. A family communication register is maintained in each resident's individual file.</p> <p>Staff understood the principles of open disclosure, which is supported by policies and procedures that meet the requirements of the Code. This was supported by documentation for applicable events in the residents' records reviewed.</p> <p>The clinical manager cannot recall an occasion where the interpreter service was required. Most current residents can speak English. For residents with limited or no understanding of English, there are staff currently employed at Lexham Gardens that can converse in the resident's first language.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>The strategic business/quality plan is reviewed annually and outlines the purpose, values, scope and direction and objectives of the organisation. The documents reviewed described annual and longer term objectives and the associated operational plans. The mission statement and philosophy of the organisation was displayed in the entrance to the facility. The facility manager is the director of this service but does not own the facility. The facility manager was able to evidence adequate information on how performance was monitored and reports included any emerging risks or issues.</p> <p>The facility manager (FM) added that the reconfiguration of increasing another eight beds to dual purpose has had no impact on the current service provided and the dual beds were already included in the quality plan as an improvement for the current year.</p> <p>The facility manager interviewed is experienced in the aged care residential care sector and has had similar roles for other organisations. The facility manager confirmed knowledge of the sector, regulatory and reporting requirements. The facility manager upskills and attends training and meetings with other like services on a regular basis. The facility manager is also a current member of two large aged care associations ensuring any changes or information about the sector is known. The facility manager is a trained assessor for one of the contracted education providers.</p> <p>The service holds contracts with the DHB for rest home, hospital and long term chronic care. At the time of the audit there are 14 rest home residents and 35 hospital residents with one rest home level care resident in hospital. Two long term chronic care residents are hospital level care.</p>
<p>Standard 1.2.2: Service</p>	FA	<p>When the facility manager is absent there is an administrator personal assistant who can cover the business management aspects of the service and the clinical manager is available to cover all clinical aspects of</p>

<p>Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>		<p>service delivery. During absence of the clinical manager a senior registered nurse is available to cover the clinical manager. The senior registered nurse is supported by the registered nurses on every shift. The registered nurse cover is provided 24 hours a day seven days a week. The reconfiguration to increase the number of dual-purpose beds will not be affected by the present day-to-day operation of this service and provision of safe services being provided to residents. Staff interviewed reported that the current arrangements work well.</p>
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	<p>FA</p>	<p>The organisation has a planned quality and risk system that reflects the principles of continuous quality improvement. This includes management of incidents and complaints, audit activities (the audit schedule and results of audits were followed through), satisfaction surveys, monitoring of outcomes and clinical incidents including infections and restraint minimisation and safe practice.</p> <p>Meeting minutes reviewed confirmed regular review and analysis of quality indicators and that related information is reported and discussed at the monthly quality/staff meetings. Staff reported involvement in quality and risk activities through audits. Any relevant corrective actions are developed and implemented to address any shortfalls. The service has undertaken three quality initiatives related to falls prevention, early alert assessment and communication tools for identification and intervention of deteriorating residents and nutrition.</p> <p>The organisation acknowledges the Health and Safety at Work Act 2015 and ensures all requirements are met and they adhere to safety procedures and practices as set out by the organisation. Employees are required at all times to conduct themselves in a manner that avoids harm to themselves and others. The service promotes health and safety measures to provide a safe environment for residents, staff and visitors to this facility. A health and safety committee exists for the purpose of implementing, maintaining and monitoring a safety programme and to provide health and safety information about any hazards present in the work place, including the identification and control of these hazards. Health and safety is on the agenda for all meetings and this was reviewed.</p> <p>Resident and family satisfaction surveys are completed annually.</p> <p>Policies reviewed covered all necessary aspects of the service and contractual requirements, including reference to the interRAI Long Term Care Facility (LTCF) assessment tool and process. Policies are based on best practice and were current. The document control system ensures a systematic and regular review process, referencing of relevant sources, approval, distribution and removal of obsolete documents. A quality consultant is contracted to ensure all policies and procedures are current.</p> <p>The facility manager described the processes for identification, monitoring, review and reporting of risks and</p>

		development of mitigation strategies.
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>Staff document adverse events and near miss events on an accident/incident form. A sample of incident forms reviewed evidenced these were fully completed, incidents were investigated, action plans developed, and actions were followed up by the clinical manager in a timely manner. Adverse event data is collated by the clinical manager and reported to the facility manager. The clinical manager reports three registers exist, one for incidents and accidents, one for medication errors specifically, and a pressure injury register was developed and implemented in 2018. These are well maintained, and summaries are completed monthly and coloured graphs are produced and displayed for staff in the staff room. The nature of the analysis performed by the clinical manager is of a high standard (eg, for medication errors which covers refusal of medication, medication not administered, administration errors, pharmacy errors and GP errors.)</p> <p>The clinical manager is fully informed of what incidents/events required notification to the Ministry of Health, HealthCERT, Public Health or other agencies. There have been two Section 31 notices completed since the previous audit both of which have been closed out.</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the requirements of legislation.</p>	FA	<p>Human resource management policies and processes are based on good employment practice and relevant legislation. The recruitment process includes referee checks, police vetting and validation of qualifications and practising certificates (APCs) where required. A sample of staff records reviewed confirmed the organisation's policies are being consistently implemented and records are maintained.</p> <p>Staff orientation includes all necessary components relevant to the role. Job descriptions were sighted. Staff records reviewed showed documentation of completed orientation and a performance review at 11 weeks post commencement date and completed annually thereafter. A schedule was reviewed which is maintained by the facility manager. Staff interviewed in a group consisting of RNs, kitchen assistant and health care assistants stated they all received at commencement of employment a full orientation and a buddy system was adopted until they felt comfortable in their designated role. Health care assistants have either completed or commenced a New Zealand Qualification Authority education programme to meet the requirements of the service provider's agreement with the DHB. The facility manager is the internal assessor for the programme.</p> <p>Currently three staff have completed level 4 and one staff member is completing level 4 (diversional therapy); Level 3 - three staff have completed and one staff member is enrolled in Level 3. Level 2 – two have completed and three are enrolled in level 2 and one is completing level 2 – cleaning. Level 1 – eight staff are completing this and all staff who work in the kitchen have completed this level 1.</p> <p>There are sufficient trained and competent registered nurses who are maintaining their annual competency requirements to undertake interRAI assessments. Records reviewed demonstrated completion of the</p>

		<p>required training and completion of annual performance appraisals.</p> <p>Twenty one (21) staff of 35 have completed and have current first aide certificates and cardio-pulmonary resuscitation. Additional staff will complete this once their two year timeframe is due to expire.</p> <p>The number of registered nurses is adequate to cover the service and for undertaking the interRAI assessments on admission and re-assessments six monthly. The reconfiguration to change a further eight rest home level beds to dual purpose did not impact on the ratio of interRAI assessments to be completed by the registered nurses. The education programme developed and implemented more than covers the educational requirements for all staff. In addition, e-learning modules are also provided to staff as part of the in-service education plan annually by the registered nurses and invited presenters.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>There is a documented and implemented process for determining staffing levels and skill mixes to provide safe service provision, 24 hours a day seven days a week. The facility adjusts staffing levels to meet the changing needs of residents. An after-hours on call roster is in place with staff reporting that good access to advice is available when needed. The general practitioner interviewed is also on call after hours. The care staff interviewed reported there were adequate staff available to complete the work allocated to them and teamwork was promoted at all times. The residents and staff interviewed supported this. Observations and review of a four-week roster cycle confirmed adequate staff cover has been provided. No bureau staff have been employed since the facility manager took over the role four years ago. Staff are replaced as required for sickness and leave as needed. At least one staff member is on duty who has a current first aid certificate each shift. Casual staff are available and are utilised as needed.</p> <p>The facility manager stated that there was more than adequate staff numbers in all roles to cover the reconfiguration of the eight beds to dual purpose beds. If acuity is increased with admissions of hospital level residents the roster and staffing is increased accordingly (without employing any new staff) to reflect appropriate cover to meet the needs of the residents.</p>
<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	<p>FA</p>	<p>All necessary demographic, personal, clinical and health information was completed in the residents' files sampled for review. Clinical notes were current and integrated with allied health service provider notes. There is very frequent documentation in individual resident files by registered nurses. Health care assistants document interventions provided and complete monitoring records as relevant for each resident every shift. This includes interRAI assessment information entered into the Momentum electronic database. The progress notes reference the GP review and any subsequent changes in the plan of care. Records were legible with the name and designation of the person making the entry identifiable.</p> <p>Archived records are held securely on site and are readily retrievable.</p>

		The clinical manager is aware of the time period that residents' files are required to be held for. No personal or private resident information was on public display during the audit.
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	FA	<p>Residents enter the service when their required level of care has been assessed and confirmed by the local Needs Assessment and Service Coordination (NASC) Service as rest home or hospital level care. Prospective residents and/or their families are encouraged to visit the facility prior to admission and are provided with written and verbal information about the service and the admission process. The organisation seeks current information from the NASC to ensure the prospective residents needs can be safely met. The facility manager updates the Eldernet website daily where there are changes.</p> <p>Family members interviewed stated they were satisfied with the admission process and the information that had been made available to them on admission. Files reviewed contained completed demographic details, assessments and signed admission agreements in accordance with contractual requirements. Service charges comply with contractual requirements.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>Exit, discharge or transfer is managed in a planned and co-ordinated manner, with an escort as appropriate. The service uses the DHB's 'yellow envelope' system to facilitate transfer of residents to and from acute care services, and ensure relevant information is communicated. There is open communication between all services, the resident and the family/whānau. At the time of transition between services, appropriate information is provided for the ongoing management of the resident. All referrals are documented in the progress notes. The examples reviewed of when a resident was transferred to the local acute care facility showed timely escalation of care. Family members interviewed reported being kept well informed of any changes in the resident's condition and escalation of care with consideration of any advance directives the resident has put in place prior. Where there has been a significant change in the resident's condition, the GP meets with the resident and family to discuss and determine the ongoing plan of care. This includes identifying 'ceilings of care', and whether the resident wants to be transferred to the acute services in the future and if so for what events / symptoms. The resident's and family members' choices are documented and communicated effectively to staff.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies</p>	FA	<p>The medication management policy is current and includes required components to meet these standards. Standing orders are not used.</p> <p>A safe system for medicine management was observed on the day of audit. The RN observed demonstrated good knowledge and had a clear understanding of their role and responsibilities related to each stage of medicine management. All staff who administer medicines are competent to perform the function they</p>

<p>with current legislative requirements and safe practice guidelines.</p>		<p>manage.</p> <p>Medications are supplied to the facility in a pre-packaged format from a contracted pharmacy. All medicines are checked against the medicine record on delivery and again at the time of administration. All medications sighted were within current use by dates. Pharmacist input is provided on request.</p> <p>Controlled drugs are stored securely in accordance with requirements and checked by two staff for accuracy when administering. The controlled drug register provided evidence of weekly stock checks and accurate entries. There are no vaccinations or other medications that require a cold chain process to be implemented stored on site. All vaccinations are provided by the GP practice. Medications that require refrigeration are stored appropriately. The temperature of the refrigerator is monitored on a daily basis and is within the required temperature range.</p> <p>There were four residents who were self-administering an inhaler. There are processes in place for ensuring residents are safe to do so, with an assessment documented and approved / endorsed by the GP. The residents are required to advise staff when they use these medicines and examples of this were sighted in a resident file sampled.</p> <p>There is an implemented process for the reporting, management of, and analysis of medication errors. The change to an electronic medicines management system and the subsequent increased in audit / monitoring and feedback has resulted in improvements in practices and processes. This is an area of continuous improvement.</p> <p>Residents and family members are informed of medicines at the time of administration and any changes in medications that have been prescribed.</p> <p>The reconfiguration arranged to change current rest home beds to dual purpose beds was discussed with the clinical manager and there has been no impact or changes required as only registered nurses are responsible for medication administration.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	<p>FA</p>	<p>The food services are provided on site by employed staff. There are two cooks and two kitchen hands that work rostered shifts over a seven day period with two staff on each day. The main meal is at lunchtime.</p> <p>Applicable staff have completed food safety training. The menu is a four week seasonal rotating menu. The current menu has been reviewed by a qualified dietitian and approved as being appropriate for the residents. The service has an approved food safety plan which has been approved by the Ministry of Primary Industries. Implementation of the food service plan has been subsequently verified by Auckland City Council (expiry date June 2020).</p> <p>All aspects of production, preparation, storage and disposal comply with current legislation and guidelines.</p>

		<p>A nutritional assessment is undertaken for each resident on admission to the facility by the registered nurse and a dietary profile is developed. The personal food preferences, any special diets, cultural needs, and modified texture requirements are made known to kitchen staff and accommodated in the daily meal plan. Special equipment to meet resident's nutritional needs, is available. Nutritional supplements are also available and used where clinically indicated / prescribed.</p> <p>Resident satisfaction with meals was verified by resident and family interviews, except for one resident who wanted a change, but had not approached the staff or the facility manager about this. This request was communicated to the facility manager during audit with the resident's prior agreement.</p> <p>Residents were seen to be given sufficient time to eat their meal in an unhurried fashion and those requiring assistance had this provided in a respectful manner. Where preferred, residents can eat their meals in their room and staff assistance is also provided as required.</p> <p>The reconfiguration of changing eight rest home level beds to dual purpose incurred no changes to meeting the nutritional needs for residents. There is adequate space in the dining room to accommodate residents currently with wheelchairs or other mobility aides. There is adequate food supplies and special diets and/or supplementary foods are catered for appropriately.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the organisation, where appropriate.</p>	<p>FA</p>	<p>If a referral is received but the prospective resident does not meet the entry criteria or there is no vacancy, the local NASC is advised to ensure the prospective resident and family are supported to find an appropriate care alternative, or alternatively, the prospective resident is placed on a wait list (currently two persons).</p> <p>If the needs of a resident change and they are no longer suitable for the services offered, the clinical manager advised a referral for reassessment to the NASC would be made and a new placement found, in consultation with the resident and whānau/family. Lexham Gardens can continue to care for residents who progress from rest home to hospital level of care. The facility manager and clinical manager advises it is rare for a prospective resident to be declined, however more common for prospective residents to have a short wait. The service has an average of 98% occupancy over the last 18 months.</p>
<p>Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.</p>	<p>FA</p>	<p>Information is documented using validated nursing assessment tools, such as a pain scale, falls risk, skin integrity, wound assessments, and nutritional screening, to identify any deficits and to inform care planning. Nursing staff undertake a 'top to toe' assessment when a resident is admitted or returns from receiving services in another healthcare facility.</p> <p>The sample of care plans reviewed had an integrated range of resident-related information. All residents have current interRAI assessments completed by the clinical manager or one of the other five registered nurses with current competency for conducting interRAI assessments. Residents and families confirmed their</p>

		<p>involvement in the assessment process and residents' goals are clearly documented.</p> <p>Prior to the interRAI assessments being reviewed / updated, members of the multidisciplinary team including the GP, activities staff, carers and resident / family are consulted about changes and the resident's progress to achieving their current goals. An annual multidisciplinary review occurs, and this is documented on a specific template in addition to the designated RN updating the interRAI assessment documents. Annual reviews have occurred for all applicable residents whose records were sampled.</p>
<p>Standard 1.3.5: Planning</p> <p>Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.</p>	FA	<p>Plans reviewed reflected the support needs of residents, and the outcomes of the integrated assessment process and other relevant clinical information. The needs identified by the interRAI assessments were reflected in care plans reviewed.</p> <p>Care plans evidenced service integration with progress notes, activities notes, medical and allied health professionals' notations clearly written, informative and relevant. The physiotherapist documents a rehabilitation plan for applicable residents and HCAs are responsible for undertaking the recommended activities and documenting that these have been completed.</p> <p>Any change in care required is documented and verbally passed on to relevant staff. The changes are also noted on the handover board in the staff office which is updated by the RN on duty every shift. Residents and families reported participation in the development and ongoing evaluation of care plans. Short term care plans were appropriately developed in sampled files for new issues including wounds / skin tears, weight loss, infections, changes in elimination needs, changing behaviour or other acute care needs. Health care assistants interviewed confirmed they are advised of changes in residents' care plans in a timely manner.</p>
<p>Standard 1.3.6: Service Delivery/Interventions</p> <p>Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.</p>	FA	<p>Documentation, observations and interviews verified the care provided to residents was consistent with their needs, goals and the plan of care. All residents and family members interviewed were very satisfied with the quality of care and service delivery at Lexham Gardens. The attention to meeting a diverse range of resident's individualised needs was evident in all areas of service provision. The GP interviewed verified that medical input is sought in a timely manner, that medical orders are followed, and that the residents are receiving appropriate care. The RN's and health care assistants confirmed that care was provided as outlined in the documentation.</p> <p>A range of equipment and resources / consumables was available, suited to the level of care provided and in accordance with the residents' needs. At least 19 residents have pressure mattresses and cushions in use. The functioning of these devices is checked and documented by HCAs every shift. There were at least 34 residents with sensor mats in use when the resident is in bed.</p>

<p>Standard 1.3.7: Planned Activities</p> <p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>	<p>FA</p>	<p>The activities programme is provided by two activities staff that are responsible for facilitating the activities over the week including weekends. One activities staff member works five days a week. A second staff member works the other two days (normally Wednesday and Thursday). A social assessment and history are undertaken on admission to ascertain residents' needs, interests, abilities and social requirements. Activities assessments are regularly reviewed to help formulate an activities programme that is meaningful to the residents. Records of participation / attendance are maintained daily, with a separate record per resident. The activities staff note a monthly evaluation on the reverse of the attendance summary every month and this is filed in the resident's record. The resident's activity needs are also evaluated as part of the formal six-monthly care plan review.</p> <p>Activities reflected residents' goals, ordinary patterns of life and include normal community activities. Individual and group activities and regular events are offered. Activities includes daily exercises, arts / crafts, entertainment, puzzles, games, keeping current with news events, visiting entertainment, church services / communion, and outings. Special events are celebrated including (but not limited to) faith-based days of significance, St Patricks day, Anzac Day, Valentine's day and residents' birthdays. There is a monthly residents' meeting and activities programme is included in the discussion. Residents verified the meeting minutes are displayed, and the most recent meeting minutes were on the activities notice board. There is a library area on site and several fish tanks. Residents and family interviewed confirmed they find the activities programme appropriate and varied, and the activities staff are enthusiastic and patient. Participation is voluntary. Residents also have personal activities that they complete with family or on their own.</p> <p>The activities programme currently covers group and individual activities to meet the needs of both rest home and hospital level residents and cover is seven days a week. The facility manager is confident the needs of all residents are adequately met with the dual-purpose service opportunities. Additional one on one activities are able to be arranged if this is required and depending on the well-being of residents at the time.</p>
<p>Standard 1.3.8: Evaluation</p> <p>Consumers' service delivery plans are evaluated in a comprehensive and timely manner.</p>	<p>FA</p>	<p>Resident care is evaluated by carers on the 24-hour record of care and reported in the progress notes when applicable and appropriate. If any change is noted, it is reported to the clinical manager or RN on duty. The clinical manager or RN's make entries in the progress notes of hospital level residents at least daily, although were normally more frequent in the sampled files. The HCAs document in the progress notes at least daily, with the RNs also making regular entries.</p> <p>The GP and allied staff document their assessments and the ongoing plan of care during each consultation.</p> <p>Formal evaluation of care plans occurs every six months in conjunction with the six-monthly interRAI reassessment, or as residents' needs change. Where progress is different from expected, the service responds by initiating changes to the plan of care and use of short term care plans. Examples of short term</p>

		<p>care plans being consistently reviewed daily by the RNs were sighted. Progress was evaluated as clinically indicated for wounds, infections, changes in elimination and falls minimisation. When necessary, and for unresolved problems, long term care plans are added to and updated. Wound care charts are used to record the condition of the wound and details interventions provided.</p> <p>The results of laboratory investigations and analysis were present in residents' files sampled. At least monthly weight and vital signs were recorded for each resident, or sooner where requested / indicated. The results are monitored over time and variances reported to the GP and dietitian where applicable. Other evaluation tools are in use included fluid balance charts, food charts, behavioural charts, pain assessment charts, blood glucose monitoring, and an exercise chart. These have been completed consistently by staff with infrequent exception. Staff are provided with reminders (via a memo), when a gap in the timeliness of any evaluation is identified. Fluid balance charts sighted have been consistently totalled by the RNs each night. Neurological observations are undertaken for at least a 12 hour period after an unwitnessed fall. Bowel charts are completed using the Bristol stool scale.</p>
<p>Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External)</p> <p>Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.</p>	FA	<p>Residents are supported to access or seek referral to other health and/or disability service providers, or their refusal of referral offer is noted.</p> <p>If the need for other non-urgent services are indicated or requested, the GP or RN sends a referral to seek specialist input. Copies of referrals were sighted in residents' files, including to the dietitian, DHB, and Cancer Society. The resident and the family/whānau are kept informed of the referral process, as verified by documentation and interviews. Any acute/urgent referrals are attended to immediately, such as sending the resident to accident and emergency in an ambulance if required.</p>
<p>Standard 1.4.1: Management Of Waste And Hazardous Substances</p> <p>Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated</p>	FA	<p>Staff follow documented processes for the management of waste and infectious and hazardous substances. Waste is collected by a contracted service provider and the local council. Appropriate signage is displayed where necessary. An external company is contracted to supply and manage all chemicals and cleaning products and they also provide relevant training for staff. Material data sheets were available where chemicals are stored and in the sluice rooms and staff interviewed knew what to do should any chemical spill event occur. A spill kit was available.</p> <p>There is provision and availability of personal protective clothing and equipment (PPE) and staff were observed using this. Storage for PPE was accessible and there are adequate stores available for replenishing the current stores visible and in use around the facility. Additional PPE stores of gloves, aprons</p>

during service delivery.		and masks were available in the storeroom for emergency events.
<p>Standard 1.4.2: Facility Specifications</p> <p>Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.</p>	FA	<p>A current building warrant of fitness is publicly displayed with an expiry 4 June 2020.</p> <p>Appropriate systems are in place to ensure the residents' physical environment and facilities are fit for their purpose and maintained. The testing and tagging of electrical equipment and calibration of bio medical equipment was current and confirmed in documentation reviewed. The date recorded when all electrical safety checks occurred is 22 May 2019. On visual inspection, the internal and external environment is well maintained. The courtyard in the centre of the facility is planted and colourful for the residents and family to enjoy visiting the facility.</p> <p>The environment was hazard free and residents were safe with independence promoted. There were two hoists available, a standing and a transfer hoist, which are checked annually.</p> <p>External areas are safely maintained with level paving and grounds that are appropriate to the resident groups and setting. Residents confirmed that they know the processes they should follow if any repairs or maintenance is required and that any requests are appropriately actioned. They were happy with the environment. Repairs are 'closed off' when addressed by the maintenance person.</p> <p>The reconfiguration to have eight rest home beds as dual purpose did not pose any issues for the current facilities and equipment available. All staff have received appropriate training for managing the hoists. There is adequate and separate storage for the hoists available when not in use.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of accessible bathroom and toilet facilities throughout the facility. This includes four rooms with shared bathrooms (two have shared ensuite and two have toilet and hand basin (no shower)). Twenty rooms, each with their own ensuite and twenty-two rooms have a toilet and hand basin only. There are additional toilets and showers in close proximity to the residents' rooms. In addition, there are two toilets one of which is a disability toilet near the main lounge/activities room. All bathrooms have appropriately secured and approved handrails provided in the toilet/shower areas and other equipment and accessories are available to promote independence. There are also separate bathrooms for staff and visitors.</p>

<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	<p>FA</p>	<p>There is adequate personal space provided to allow residents and staff to move around within their bedrooms safely. There are 42 single rooms and 4 double rooms. Rooms are personalised with furnishings, photographs and other personal items on display.</p> <p>The door width and room sizes of the residents' rooms designated for dual purpose are adequate for hospital level care beds and for an ambulance gurney/fold up stretcher to be used. There is room for use of wheelchairs, mobility aides and staff and residents reported the adequacy of the individual rooms.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining needs.</p>	<p>FA</p>	<p>Communal areas are available for residents to engage in activities. The dining and lounge areas are spacious and enable easy access for residents and staff. Residents can access areas for privacy. There is one smaller lounge available for this purpose. The furniture in the lounges and dining room is appropriate to the setting and residents' needs.</p> <p>There is adequate space to accommodate wheelchairs in the dining room and large lounge if required with the reconfiguration of additional dual-purpose beds.</p>
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	<p>FA</p>	<p>Laundry is contracted out to an external contracted provider. Only residents' personal clothing is washed and dried at the facility in the laundry provided. The laundry is spacious and both care and cleaning staff are responsible for the personal clothing. Care staff and a cleaner interviewed demonstrated a sound knowledge of the laundry processes, dirty and clean flow and handling of any soiled linen. Residents and family interviewed reported the personal clothes are managed effectively and returned in a timely manner. There are separate named baskets for each individual resident. When linen is folded and placed in the baskets these are given out by staff and put away in the residents' own rooms. There has been no impact on the cleaning and laundry services with the increase in dual purpose beds.</p> <p>There is a small designated cleaning team which have received appropriate training. These staff have completed and/or are completing the New Zealand Qualifications Authority Certificate in cleaning (Level 2) as confirmed in interview of cleaning staff and training records. Chemical are stored in a lockable cupboard and were in appropriately labelled refillable containers. The cleaning trolley is stored in a locked sluice room when not in use.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security</p>	<p>FA</p>	<p>Policies and procedures and guidelines for all emergency planning, preparation and response are displayed and flip charts are displayed around the facility to guide staff. Disaster and civil defence planning guides</p>

<p>Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>		<p>direct the facility in their preparedness for disasters and described the procedures to be followed in the event of a fire or other emergency. The current fire evacuation plan was approved by the New Zealand Fire Service on the 27 March 2000. A fire evacuation drill takes place six monthly with a copy sent to the New Zealand Fire Service. Records were reviewed. A discussion with all staff was held post fire drill and this was documented and sighted. Two fire drills were provided so that all staff could attend one or the other. The first drill was held on 30 June 2019 and repeated on the 01 July 2019. The orientation programme includes fire safety and security training. Staff interviewed confirmed their awareness of the emergency procedures.</p> <p>The facility manager stated that the fire evacuation plan was unchanged in regard to the reconfiguration approval as no structural changes had been made to the building and the capacity of residents was not changing.</p> <p>Adequate supplies for use in the event of a civil defence emergency including food, water, blankets, torches both hand and head variety, mobile phones and a gas barbecue were sighted and meet the requirements for the 50 residents at this facility. Water storage meets the requirements of the local council. There is a generator on site and external emergency lighting which would run off the generator as well as emergency lighting in the facility. These resources are regularly tested and recordings were validated. Three large bins which are locked and checked regularly contain all emergency resources for the event of an emergency. These are labelled and all staff interviewed were aware of the locality of the bins outside should they be required.</p> <p>Call bells alert staff to residents requiring assistance. Call system audits are completed on a regular basis and resident and families reported staff respond in a timely manner. Call bells were observed in all service areas within the facility.</p> <p>Appropriate security arrangements are in place. Door and windows are locked at a predetermined time and the facility is checked by staff. Cameras are evident around the facility and signage is available. No changes were required to the call bell, security or emergency preparedness in view of the reconfiguration as all systems were already in place.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	<p>FA</p>	<p>All residents' rooms and communal areas are heated and ventilated appropriately. Underfloor heating is available throughout the facility and an even temperature is maintained. All bedrooms have an external window and natural light. The rooms near the courtyard open onto the courtyard itself. Areas were warm and well ventilated and residents and families interviewed confirmed that the facility is maintained at a comfortable temperature. Blinds and curtains are at the windows.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The service provides a managed environment that minimises the risk of infection to residents, staff and visitors by the implementation of an appropriate infection prevention and control (IPC) programme. Infection control management is guided by a current infection control policies and procedures. The infection control programme is reviewed annually.</p> <p>Residents with a multi drug resistant organism (MDRO) have this clearly detailed in their care plan.</p> <p>The clinical manager is the designated IPC co-ordinator and works with the support of the RNs. The role and responsibilities of the IPC coordinator is documented. Infection control matters, including surveillance results, are reported monthly to the facility manager and discussed monthly in the staff meetings.</p> <p>Staff and residents are offered an annual influenza vaccination. Completed consent forms were sighted. All except seven residents consented for an influenza vaccination in 2019. In addition, seven residents were provided with the shingles vaccine. Staff interviewed understood their responsibilities to prevent the spread of infection. Appropriate personal protective equipment (PPE) is available and was observed to be in use. There have been no outbreaks of infection in 2018 / 2019 to date.</p> <p>Compliance with key aspects of policy is monitored via the internal audit programme.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>The infection prevention and control co-ordinator (IP&CC) has appropriate skills, knowledge and qualifications for the role. The IP&CC has completed training on this topic, most recently the e-learning programme on 'learn online'. If required expert advice can be sought from the community laboratory and/or the general practitioner, and public health. An external infection control consulting services is also available if required.</p> <p>The IP&CC has access to residents` records and diagnostic results to ensure timely treatment and resolution of any infections.</p> <p>The infection prevention and control co-ordinator confirmed at interview the availability of resources to support the management of any outbreak of an infection should this be required.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and procedures for the prevention and control of</p>	FA	<p>The infection prevention and control policies reflected the requirements of the infection prevention and control standard and current accepted good practice. Policies were current. A paper-based copy of all the policies are available for staff to access in the staff office. Where there is significant change in the content of a policy, or a new policy has been developed, staff are informed and are required to read and sign the document. The IC manual was last reviewed in June 2019. Staff have read the updated manual and</p>

<p>infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>individually signed to confirm that they have done so.</p> <p>Care delivery, cleaning, and kitchen staff were observed following organisational policies, such as appropriate use of hand sanitisers, good handwashing techniques and use of disposable gloves, as appropriate. Hand washing and sanitiser dispensers were available in designated areas around the facility. Staff interviewed verified knowledge of infection control policies and practices.</p>
<p>Standard 3.4: Education</p> <p>The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The staff education plan includes infection prevention and control. This commences during orientation and has continued in the ongoing education programme. The education planner for 2018 and 2019 has been implemented. The infection prevention and control nurse provides some education sessions. Others are provided by e-learning or included in topics provided by the registered nurses. Records are maintained of all infection control education provided.</p> <p>Education with residents is generally on a one-to-one basis and included aspects of personal hygiene and the prevention of urinary tract infections or the treatment plan for new infections.</p>
<p>Standard 3.5: Surveillance</p> <p>Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>Surveillance is appropriate to that recommended for a long term care facility. This includes urinary tract infections, wound infections, eye infections, chest infections, multi drug resistant organisms, cellulitis, and other infections. When an infection is identified a record of this is documented on the infection notification form by the RN who is responsible for the resident's care at the time of diagnosis, and also detailed in the applicable resident's file. The infection prevention and control nurse reviews all reported infections and maintains a register including the name of the resident, the type of infection, the results of laboratory investigations (if applicable), the treatment and the outcome. The GP interviewed confirmed being informed in a timely manner of residents with suspected infections. Five residents' infections as detailed in the sampled residents' files have been included in the infection surveillance data in the month the infection was diagnosed.</p> <p>Monthly surveillance data is collated and analysed to identify any trends, possible causative factors and required actions. Results of the surveillance programme are shared with staff. New resident infections are communicated to staff via the shift handover and handover whiteboard.</p> <p>There have been no outbreaks of infection since the last audit.</p>

<p>Standard 2.1.1: Restraint minimisation</p> <p>Services demonstrate that the use of restraint is actively minimised.</p>	FA	<p>Policies and procedures meet the requirements of the restraint minimisation and safe practice standards and provide guidance on the safe use of both restraints and enablers. The restraint coordinator provides support and oversight for enabler and restraint management in the facility. The restraint coordinator was not available for interview, but the clinical manager understood the organisation's policies, procedures and practice and the responsibilities of the role. On the day of the audit, 11 restraints were in use consisting of one resident using a lap belt, and 10 residents using bedrails. No enablers were in use. Enablers were the least restrictive and used voluntarily at the residents' request.</p> <p>Restraint is used as a last resort when all alternatives have been explored. This was evident on review of the restraint records and from interviews with staff.</p>
<p>Standard 2.2.1: Restraint approval and processes</p> <p>Services maintain a process for determining approval of all types of restraint used, restraint processes (including policy and procedure), duration of restraint, and ongoing education on restraint use and this process is made known to service providers and others.</p>	FA	<p>The restraint approval is authorised by the registered nurse who is the restraint coordinator (RC) and general practitioner (GP). It was evident from review of restraint approval forms and residents' records and interviews with staff and the clinical manager that there are clear lines of accountability that all restraints have been approved and the overall use of restraints is being monitored and analysed. Evidence of family/whanau involvement in the decision making was on record in each case. Use of a restraint or an enabler (when used) is part of the plan of care.</p>
<p>Standard 2.2.2: Assessment</p> <p>Services shall ensure rigorous assessment of consumers is undertaken, where indicated, in relation to use of restraint.</p>	FA	<p>Assessments for the use of restraint were clearly documented and included all requirements of the Standard. The RN on any shift undertakes the initial assessment with the restraint coordinator's involvement and input from the resident's family/whanau. The RN interviewed described the documented process. Families confirmed their involvement. The GP is involved in the final decision on the safety of the use of the restraint. The assessment process using a restraint/enabler questionnaire identified the underlying cause, history of restraint use, cultural considerations, alternatives and associated risks involved. The desired outcomes were to ensure the resident's safety and security. Completed assessment were sighted in the records of residents who were using a restraint.</p>

<p>Standard 2.2.3: Safe Restraint Use</p> <p>Services use restraint safely</p>	<p>FA</p>	<p>The use of restraint at this facility is actively minimised and the clinical manager described alternatives to restraints and that this was discussed with family and staff, for example, low beds. When restraints are in use, frequent monitoring occurs to ensure the resident is safe. Records of monitoring had the necessary details. Access to advocacy is provided and all processes ensure dignity and privacy are maintained and respected by staff and others.</p> <p>A restraint register is maintained and updated regularly. The register was reviewed and contained all residents currently using a restraint and sufficient information to provide an auditable record.</p> <p>Staff have received training in the organisation's policy and procedures and in related topics, such as managing and supporting people with challenging behaviours. Staff interviewed understood that the use of restraint is to be minimised and how to maintain safety when in use.</p>
<p>Standard 2.2.4: Evaluation</p> <p>Services evaluate all episodes of restraint.</p>	<p>FA</p>	<p>Review of resident's records showed that the individual use of restraints is reviewed and evaluated during care plan and interRAI reviews, six monthly restraint evaluations and at the restraint reviews annually. Families confirmed their involvement in the evaluation process and their satisfaction with the restraint process.</p>
<p>Standard 2.2.5: Restraint Monitoring and Quality Review</p> <p>Services demonstrate the monitoring and quality review of their use of restraint.</p>	<p>FA</p>	<p>The restraint team undertakes a six monthly review and an annual review of all restraints in use which includes all the requirements of the Standard. Restraint use is reported by the restraint coordinator at the quality and staff meetings. Minutes of meetings confirmed this includes analysis and evaluation of the amount and type of restraint use in the facility. If any trends are identified, information is fed back to staff. A six monthly restraint audit is carried out. Any changes are implemented if indicated and any reduction in restraint is noted.</p>

Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

No data to display

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, these is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding
<p>Criterion 1.2.4.3</p> <p>The service provider documents adverse, unplanned, or untoward events including service shortfalls in order to identify opportunities to improve</p>	CI	<p>A quality improvement initiative based on pressure injury (PI) prevention was initiated in July 2018 by the clinical manager (who is responsible for any adverse events, incidents and accidents) after monthly quality indicators reflected an increased number of stage 2 pressure injuries being reported over the previous six months with three incidences of stage 2 pressure injuries identified. The aim was to reduce the occurrence of PIs by having preventative measures in place and early detection and management of PIs to prevent escalation of stage one to stage two or three. A three-month focus was pursued to October 2018. From a business and quality perspective the aims were to improve the resident's quality of life by decreasing the occurrence or severity of PIs, to reduce the cost of dressing products and registered nurse input/time, and to teach the staff that PIs reflect on care provided and most are avoidable. Proposed solutions were discussed, and an action plan developed and implemented to</p>	<p>A continuous improvement rating is made for achievement beyond the expected full attainment for the high standard of documentation for managing PIs. The quality, medical and nursing records were audited and the outcomes of decreased PIs, better measurement, management and maintenance of skin integrity and improvement in incident reporting was evident. There has been a significant reduction in number of stage two PIs because of the PIs being identified and managed in the early stages preventing them from escalating to stage two or above. A register of PI equipment used was reviewed and this was made available for all staff. The outcome changes have been implemented permanently and staff will continue the annual PI management training with the next training already planned and a follow-up clinical audit has been introduced on two</p>

<p>service delivery, and to identify and manage risk.</p>		<p>inform staff through the monthly statistics presentation at the staff meetings, to increase the staff training on PI and competency assessments and education on how to develop comprehensive resident care plans. In addition to this, all PI equipment and resources was reviewed and a PI register was developed. The PI management policy was reviewed, and the clinical manager ensured all possible resources were available for staff and these were referenced. This has reduced the numbers of PIs.</p>	<p>occasions and evaluated.</p>
<p>Criterion 1.2.7.5 A system to identify, plan, facilitate, and record ongoing education for service providers to provide safe and effective services to consumers.</p>	<p>CI</p>	<p>A palliative outcome initiative project was commenced after multifaceted problems were discussed at the registered nurses meeting in relation to registered nurses not being confident in discussing palliative care with the residents or families. The issues included families not always having insight into their relatives' prognosis and often ending up in a highly emotional situation when it came to the last days of life and resident/families not being prepared to face the inevitable when a person dies.</p> <p>The aim of the project was to identify the residents who would benefit from a palliative care approach and to promote their quality of life by preparing both the resident and the family for the inevitable. From a quality perspective this increased staff knowledge and preparation of families and residents would help reduce the number of unnecessary hospital admissions, reduce the emotional stress on the registered nurses, assist informed discussions and proactive decisions by the multidisciplinary team and assist with the development of advanced care plans where appropriate.</p>	<p>A continuous improvement rating is made for achievement beyond a full attainment for this registered nurses palliative care quality improvement project which was based on initially furthering their education by completing the fundamental of palliative care training earlier this year and being part of the palliative outcomes initiative programme which is an Auckland wide approach to primary palliative care supported by the local hospice. The service now has access to the electronic palliative care pathway activation proactive advisory service. Resources are readily available and a supportive palliative care indicator tool is also available and can be discussed with the hospice link nurse. Evaluation of the courses and the processes adopted by the registered nurses in relation to palliative care management were initiated and the feedback has been very positive. Once the prognosis is discussed with the family, plans are now made in advance and staff training and feedback is accessible to ensure all situations are managed effectively for residents. The resident care plans are now made in advance which clearly reduces stress on the resident, their families and health care staff. The advantage of having support from hospice when required provides the opportunity for RNs to understand palliative care better and the resident's quality of life is significantly improved.</p>

<p>Criterion 1.3.12.1</p> <p>A medicines management system is implemented to manage the safe and appropriate prescribing, dispensing, administration, review, storage, disposal, and medicine reconciliation in order to comply with legislation, protocols, and guidelines.</p>	<p>CI</p>	<p>The medication management policy and procedure clearly described the processes to ensure safe administration of all medications. This includes competency requirements, prescribing, recording, medicine reconciliation, processes when an error occurs. The sighted policies meet the legislative requirements of best practice</p> <p>An electronic medicine management system is now being utilised. This commenced in November 2018. The medicine records reviewed on the electronic system used have been reviewed by the GP at least three monthly. All prescriptions sighted were accurately documented by the GP and checked by the pharmacist. Any allergies/sensitivities are flagged on this system. There are current photographs of each resident.</p> <p>In 2018, audits of medicine related practices identified issues with the legibility of some prescriptions, indications for pro re nata medicines were not always noted and discontinued medicines were not consistently dated and signed. Medicine rounds were not time efficient due to paper based systems and the occasions when medications had not been administered as required or were refused was higher than previously noted. A decision was made to adopt an electronic medicines management system. In November 2018 pre introduction of this system there were 55 medicine refusals, 27 medications not administered as prescribed and one administration error documented.</p> <p>Prior to the system being introduced all staff involved in medicines management were provided with training on using the new system. Feedback from staff noted the system to be user friendly. A number of additional benefits were realised through using the system. The prescriber could remotely prescribe or amend medicine records in real time following conversations with the RNs (eg, for a resident with an infection) and or for those residents returning post discharge from the DHB. Verbal orders have not been required since the move to the electronic system. Orders and re-orders for medicines</p>	<p>The service has moved to use of an electronic medicine management system that has improved medicine management practices and enhanced residents' safety. The audit functions within the electronic medicine management system have facilitated more frequent audits of keys components of medicine management to be conducted. Actions plans developed and implemented for all areas where improvements are identified as required, and the effectiveness evaluated via ongoing audits, until the required changed have been imbedded in practice. Improvements have been noted in the legibility and content of medicine orders, the monitoring of pro re nata medicines and effectiveness of these, and a reduction in the occasion's medicines are refused by residents or were not signed as administered as prescribed.</p>
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	<p>could be put through electronically to the pharmacy during the medicines round where required. Staff reported that these additional functions meant they had more time to spend with residents, medicines delivery was timely with no delays experienced in prescribing or receipt from pharmacy. The clarity of prescriptions and real time communication between pharmacy and prescriber meant less issues whilst dispensing medicines from the pharmacy.</p> <p>After introduction, regular audits were undertaken using the audit functions and reports within the electronic medicine management system. Information accessed enabled immediate reviews of key processes without the delay of manually gathering and collating data previously encountered. The audits were frequent at the beginning while staff were learning the new system. Audit results were communicated to applicable staff via memo, along with the improvements required. The audit findings verified that all required aspects of medicine prescribing had improved – all medicines ordered were legible and the doses clear. Indications for pro re nata medicines were noted and discontinued medications clearly noted along with the rational.</p> <p>Using the ‘dashboard’ functions management could confirm that medicine records had been reviewed by the general practitioner at least three monthly. Residents’ refusal of medicines and their individual use of pro re nata (PRN) medicines were easily traceable. Staff, are required to document an assessment prior to and post administration of pro re nata medicines. As assessments and evaluations are recorded electronically within the medicines management programme it supports more timely evaluation of outcomes or responses to medication and communication with the GP.</p> <p>Management and staff confirm that since moving to the electronic medicines systems there have been significant improvements and confidence in the medicines system. This includes a noticeable reduction in the number of occasions a medicine is documented as refused or found to have not been administered for any reason. A comparative audit completed in</p>	
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		March 2019 found there were seven medication refusals, three medicines not administered and no other medication errors. Data continues to be graphed and reported to staff monthly. An incident form is completed every time a resident refuses a medicine prescribed for regular administration.	
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End of the report.